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# controversial topics in surgery

## Paid organ donation

ARTHUR J MATAS AND ANYA ADAIR & STEPHEN J WIGMORE

Dr Matas makes a persuasive case for launching a pilot trial of incentives to increase the supply of kidneys for transplantation. Ms Adair and Professor Wigmore, on the other hand, urge continued reliance on altruism: 'In the setting of paid donation,' they write, 'informed consent is often of dubious quality with the risks of surgery often not being properly explained or understood.' Unacceptable? Of course but let us be clear here. The fact that donors are enriched is not the problem. The problem is that such cash-for-kidney exchanges are conducted illegally. This is the source of the danger and degradation that Adair and Wigmore describe so well.

All ethical people deplore exploitation of the poor but unless the supply of organs is increased, trafficking will continue to flourish. Markets will be driven further underground – making it all the more hazardous for donors and patients alike – or they will simply move to another region as we have seen happen over the past few years. Even if global trafficking could somehow be eradicated, we confront the tragic trade-off of an even higher death toll from renal failure. The only solution is to incentivise donation under conditions that are medically and morally scrupulous.

Hence Matas's call for a trial of incentives with safeguards for donor health and carefully obtained, informed consent at its core. In his proposal, for example, trials would operate only in countries that could provide appropriate oversight of government-sponsored material incentives. To ensure transplantation for all patients, the kidney would be allocated to the first person on the waiting list (similar to allocation for deceased donor kidneys). Donor and patient would have limited, if any, access to one another. In the end everyone benefits, not just the well-off. This is the precise opposite of the rapacious organ trade.

Unless desperate patients can receive new kidneys they will continue to haunt the shady organ bazaars that thrive on the vulnerability of impoverished donors. Adair and Wigmore, though claiming to disagree with Matas's proposal, inadvertently provide powerful rationale to support it.

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## The case for a regulated system of incentives for living kidney donation

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The major reason to consider incentives for living kidney donation is that transplant candidates are suffering and dying while waiting for a transplant. The shortage of organs has become a major crisis in almost all countries that do transplants (the exception is Iran, which has a donor incentive programme). For patients with end-stage kidney disease, a transplant provides significantly longer survival and significantly better quality of life than dialysis.<sup>1,2</sup> In addition, the longer candidates wait on dialysis, the worse the

transplant results.<sup>5</sup> Therefore early transplantation confers important advantages.

As transplant results have improved over the last three decades, more patients with end-stage kidney disease have opted for a transplant; yet there has not been a commensurate increase in the number of available organs.<sup>4,5</sup> As a consequence, the number of people on the waiting list, the time from listing to transplant, and the mortality while waiting continue to increase. In the 1980s a newly

listed candidate in the US could expect to wait about one year for a transplant; currently, the wait is more than five years (and in some areas of the country is approaching ten years). Between 2000 and 2009, over 69,000 waiting-listed candidates in the US were removed from the list because they died or became too sick to transplant.<sup>4</sup> Candidates over 60 years of age and newly added to the list have a greater chance of dying while waiting than of being transplanted.<sup>6</sup> Incentives may increase donation and save lives.

At the same time, many potential (altruistic) donors do not come forward because of the 'costs' associated with the evaluation and donation:

1. risk of dying and having no life insurance;
2. concerns about long-term healthcare and (in the US) having no health insurance;
3. lost 'wages' while out of work for the surgery and recovery; and
4. costs of travel to the transplant centre for the evaluation and the surgery.

Removal of these disincentives would allow more donors to come forward.

There is another reason to consider a regulated system of incentives. Currently, transplant tourism and 'unregulated' free markets exist throughout the world.<sup>7</sup> Only the wealthy receive kidneys in these markets. At the same time there is little oversight of the donor evaluation, no long-term donor follow-up and no protection for either the donor (who often does not receive what was promised) or the recipient. Developing a regulated system of incentives may decrease the waiting list and minimise or eliminate these unregulated markets.

Incentives could also be considered for deceased donation. But the major reason to focus on living donation is that if all potential deceased donors became actual donors (in the US) there would still be an organ shortage.<sup>8</sup> In addition, with deceased donation it is difficult to determine who would receive the incentive or what happens if family members disagree.

The concept of incentives for donation is controversial, so definitions are critical. I support a very specific system in which there is either no or very limited contact between donor and recipient.<sup>9,10</sup> The government (or designee) would provide the incentive to the donor and the kidney would be

**TABLE 1** Misleading arguments used against a regulated system of compensated donation

**1) Arguments that do not distinguish between donation and compensation**

- a) The compensated donor would be harmed.
- b) Genuine consent would be impossible.
- c) Not enough is known about long-term risk to donors.

**2) Arguments with no supporting data**

- a) Conventional donation would decrease.
- b) Donation should be altruistic.
- c) Trust in the government or in doctors would erode.

**3) Arguments that are not logical**

- a) Unregulated systems have failed elsewhere.
- b) Congress and various professional societies have already voted to prohibit compensation, so we should end the discussion.
- c) The sale of blood has failed.
- d) Organised religions would object.
- e) Financial incentives would constitute coercion.
- f) A regulated system would be abused.
- g) We should do more preventive medicine.
- h) Other current initiatives are working.
- i) A regulated system would be similar to slavery or prostitution.
- j) Once we start, we cannot return to altruistic donation.
- k) Other countries would continue or initiate unregulated systems.

**4) Arguments that equate compensation with wrongful commodification of the body**

**5) Arguments that compensation would lead to exploitation of the poor**

allocated to the first person on the waiting list (similar to allocation for deceased donor kidneys) so that all candidates on the list would have the opportunity to be transplanted.

The donor evaluation would be done (similar to our current donors) by a panel, including a surgeon, nephrologist, social worker, coordinator and advocate, each of whom would be concerned that the donor understood the risks associated with the procedure. Only citizens and legal residents would be considered as donors so as to ensure long-term healthcare and follow-up. Because the system would be government-based there would be appropriate regulation and oversight – ie, this is not a free market. I believe that trials of incentives should only be developed in countries that can provide the appropriate oversight. Importantly, because dialysis is so much more expensive than a transplant, a programme of incentives for donation could be cost-neutral to the healthcare system.

Different trials could provide different options for incentives. At the very minimum, disincentives should be eliminated. In addition, there could be a tax credit, college tuition, a direct payment, or a small direct payment with additional small payments at each follow-up visit (which would both minimise the risk of candidates donating for ‘quick cash’ and help ensure long-term follow-up). Different incentives may appeal to different candidates.

Numerous arguments have been proposed against a regulated system of incentives; on detailed analyses each fails.<sup>9,11–15</sup> These arguments can be divided into five major categories (Table 1).

1. Some arguments (eg potential risk to the donor) ignore the fact that the risks would be the same as for our current donors. We accept living donation; therefore, to be successful, arguments must differentiate incentivised donation from our current donation.
2. Some arguments (eg donation will decrease) can only be answered by a trial. It is naive to believe that there is a dichotomy between ‘altruistic’ donation and ‘incentivised’ donation. Many of our current so-called ‘altruistic’ donors have numerous additional motives and many who come forward because of incentives (or elimination of disincentives) will also have altruistic motives.
3. Some arguments are totally illogical (eg unregulated markets have failed elsewhere) or used as ‘scare tactics’ (eg the sale of blood failed; people will be coerced).
4. Arguments that incentives will lead to commodification of the human body ignore the fact that we already compensate people for sperm, ova, surrogate motherhood and, in court cases for loss of body parts, without any loss of humanity.

Arguments that the poor will be exploited ignore a fundamental tenet of Western society – that people be allowed to control their own destiny. A fully informed individual should be free to decide whether or not the benefits outweigh the risks. Nevertheless, sensitivity to this concern should dictate careful development of trials and appropriate oversight. Donors are heroes; there is nothing inherently wrong with rewarding heroes.

Many argue that we should not consider incentives until other possible initiatives have been tried. But the reality is that in the last decade – with the introduction of expanded criteria donors, donation after cardiac death, non-directed donors, paired exchanges and increased public education – there has not been any significant increase in the number of transplants.<sup>4</sup> If we wait years to see if continuing these initiatives work, the list (and waiting time) will only get longer. Others argue that if a trial failed we could not revert to the current system but we could develop a limited trial with a planned one-year moratorium to evaluate results.

Aside from the ‘ethical’ concerns, there are also practical issues that would have to be addressed. For example, should there be a minimum age? Who would administer the programme?

At the end of the day, we need to decide whether to support the status quo that has led to the organ shortage (and to our patients suffering and dying while waiting for a transplant) or to initiate trials of incentives in order to increase donation (recognising and addressing the concerns). Establishment of a regulated system of incentives has the potential of saving lives and shortening the waiting list, while simultaneously protecting the health and dignity of donors. It is time to lift the ban against incentives and initiate clinical trials to determine whether these possibilities can be achieved.

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